MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04094

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 553 Penn
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Harry Joseph Bonell

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nellie Hunt Bonell
6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) May 28 - 1906

8. AGE: Years	Months	Days	If less than one day
40	11	21	...hrs. ...min.

9. Birthplace Havre de Grace
(Town, county, and state)
10. Usual occupation Clerk
11. Industry or business —

FATHER
12. Name Harry J. Bonell
13. Birthplace Wilmington Del.

MOTHER
14. Maiden name Margaret P. Dayfield
15. Birthplace Havre de Grace

16. Informant Nellie H. Bonell (wife)
Address 553 Penn

17. Burial Date thereof 5/22/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Lir
Location Havre de Grace
18. Funeral director Pennington & Son
Address Havre de Grace

19. May 27 1947 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1946, to May 17 1947, and that I last saw h... alive on May 17 1947.

	DURATION
Immediate cause of death	
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions Cachexia	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles J. Foley 2nd M. D. or other
Address Havre de Grace Date signed May 24, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

0409580
Reg. Dist. No.

1. PLACE OF DEATH:
County Harford Co.
City or town Abingdon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6yr
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Abingdon
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Thomas Braston, Jr.

3. (b) Social Security Number 218-01-7580

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1900

8. AGE: Years	Months	Days	If less than one day
46	10	2	16 hrs. 45 min.

9. Birthplace Bay View, Baltimore Co. Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business none
FATHER 12. Name Thomas Braston
13. Birthplace King Williams Co. Va.
MOTHER 14. Maiden name Keziah Fountain
15. Birthplace Churchton A.A. Co. Md.
16. Informant Keziah Brahton
Address Abingdon Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 (month) 16 (day) 47 (year)
Cemetery or crematory John Wesley cemetery
Location Abingdon Md.
18. Funeral director Harland C. McConnaughey
Address Abingdon Md
19. May 16 1947 (Date rec'd by registrar) Mame M. Maulsdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1947, at 1015 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-8-41 1941 to 5-13 1947 and that I last saw h.. alive on 5-13 1947

Immediate cause of death	DURATION
Chronic glomerular nephritis with hypertension, edema	7 yrs
Due to	
Due to	
Other conditions Uremia	11 days

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op. none
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Fred O Hodous, M.D. M. D. or other
Address Edgewood, Md. Date signed 5-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04096

CERTIFICATE OF DEATH

Reg. Diat. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Stephensey
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Catherine Jane Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: John Brown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): September 14, 1873

8. AGE:

Years	Months	Days	If less than one day
74	8		..... hrs. ..... min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Lovett, Pa.

MOTHER
14. Maiden name: Catherine J. Wilson
15. Birthplace: Unknown.

16. Informant: John L. Brown.
Address: Joppa, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 17, 1947 (month) (day) (year)

Cemetery ~~or crematory~~: St Paul Lutheran

Location: Near Aberdeen

18. Funeral director: Henry Taxing & Sons

Address: Aberdeen Md.

19. May 16 1947 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14th 1947, at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945, to May 14 1947

and that I last saw h[illegible] alive on May 12 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G B Jastram M.D. M. D. or other

Address: Aberdeen Md Date signed 5/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04097

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford County
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 50 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Belair
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 106. E. Gordon St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence Brown

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widower

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2nd, 1869

8. AGE:

Years	Months	Days	If less than one day
78	1	4	hrs. min.

9. Birthplace: Brooklyn, New York (Town, county, and state)
10. Usual occupation: Retired Salesman
11. Industry or business:
12. Name of FATHER: Simeon L. Brown
13. Birthplace of FATHER: New York
14. Maiden name of MOTHER: Jennie Hegeman
15. Birthplace of MOTHER: New York
16. Informant: Herbert W. Brown
Address: 71 Jefferson Blvd, Staten Island N.Y.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9, 1947 (month) (day) (year)
Cemetery or crematory: Cokesbury
Location: Abingdon Md.
18. Funeral director: Howard K. McCormaston
Address: Abingdon Md.
19. May 12 19 47 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6th 19 47 at 6 50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6th 47 19 to same 19
and that I last saw him alive on same 19
Immediate cause of death: Coronary occlusion — DURATION
Due to: —
Due to:
Other conditions: Cataract (left eye) Cryptorchidia (right)
Include pregnancy within 3 months of death.
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: John F. Noguera MD. M.D. or other
Address: Harford Mem Hosp Date signed 5/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93c

04098

CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Harford

City or town: Rural Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Creswell
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Richard Herbert Cullum

3.(b) Social Security Number: 212-14-3052

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Josie J Thompson

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): April 15 - 1883

8. AGE: Years: 64 Months: Days: If less than one day: hrs. min.

9. Birthplace: Creswell Harford Co. Md
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: William Cullum

13. Birthplace: Harford Co

MOTHER 14. Maiden name: Martha J Cullum

15. Birthplace: Harford Co Md

16. Informant: Mrs Richard H. Cullum

Address: Bel Air Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13 - 1947 (month) (day) (year)

Cemetery or crematory: Calvary

Location: Near Creswell Harford Co

18. Funeral director: Henry Fleming Sons

Address: Aberdeen Md

19. May 12 1947 (Date rec'd by registrar) Nellie F. Tilley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1947 at 6:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to May 1947 and that I last saw her alive on May 9 1947

	DURATION
Immediate cause of death: Acute pulmonary edema	15 min.
Due to: Rheumatic cardiovascular disease	7 yrs.
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Ralph Horsey M.D.

Address: Churchville M. D. or other

Date signed: May 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

04099

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hospital, Havre de Grace
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Boy Dubin

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 26th/47 at 3:45 PM

8. AGE: Years	Months	Days	If less than one day
—	—	—	9 hrs. 30 min.

9. Birthplace: Harford Memorial Hosp. (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Florence Edwin Dubin
13. Birthplace: New York

MOTHER
14. Maiden name: Florence Newman
15. Birthplace: New York City

16. Informant: Hospital Records
Address: Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/28/47 (month) (day) (year)
Cemetery or crematory: Mount Hebron
Location: Brooklyn N.Y.

18. Funeral director: Pennington & Son
Address: Havre de Grace

19. May 27 1947 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27th 1947 at 1:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26th 1947 to May 27th 1947 and that I last saw h[illegible] alive on May 26th 1947

Immediate cause of death	DURATION
Respiratory and Circulatory failure	hours
Due to: Prematurity (6 mos. of fetal life)	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Noguera MD M. D. or other
Address: Harford Memorial Hosp. Date signed: 5/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bl-a)

CERTIFICATE OF DEATH

04100

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7 Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Annie M. Duff

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Daniel A. Duff
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23, 1879

8. AGE: Years: 68 | Months: 1 | Days: | If less than one day: hrs. min.

9. Birthplace: Harford Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: George Dennis
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden name: Alice Mitchell
15. Birthplace: Harford Co., Md.

18. Informant: Mr. Kendall Duff
Address: Aberdeen, Md. R.D. #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26, 1947 (month) (day) (year)
Cemetery ~~or crematory~~: Rock Run
Location: Near Darlington, Md.

18. Funeral director: Henry Tarring & Sons
Address: Aberdeen, Md.

19. May 26 1947 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24th 1947 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 25 1946 to May 24 1947 and that I last saw h~~er~~ alive on May 24 1947

Immediate cause of death	DURATION
Chronic Nephritis	
Due to Arteriosclerotic Cardio-Vascular disease	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Lamey M.D. M. D. or other
Address: Aberdeen, Md. Date signed: 5/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04101

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Rural Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Weeks
Hospital, institution, or street address where death occurred:
Harford Nursing Home
How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 453 Green St
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: JENNIE E. FORD

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Wm Ford
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 25, 1879

8. AGE:

Years	Months	Days	If less than one day
67	11	3	— hrs. — min.

9. Birthplace: N. Y. (Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business: Retired
FATHER 12. Name: Fred. Wells
13. Birthplace: N. Y.
MOTHER 14. Maiden name: Ida Sarah Griffin
15. Birthplace: N. Y.
16. Informant: Mrs. Myrtle Haines
Address: Havre de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31, 1947 (month) (day) (year)
Cemetery or crematory: Arlington Meth. Cem.
Location: Harford Co. Md.
18. Funeral director: P. Madison Mitchell
Address: Havre de Grace, Md.
19. May 30 1947 (Date rec'd by registrar) Bertha B. Knight Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 28 1947, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 28 1947, to MAY 28 1947 and that I last saw her alive on MAY 28 1947

	DURATION
Immediate cause of death: CEREBRAL HEMORRHAGE	6 HOURS
Due to: PROB. HYPERTENSION AND ARTERIOSCLEROSIS	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE
Date of op.:
Autopsy results: NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robt A. Barthel M.D. (M. D. or other)
Address: FOREST HILL, MD. Date signed: 5/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

04102

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 181

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County HARFORD

City or town ABERDEEN - RURAL

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HARFORD

City or town ABERDEEN - RURAL

(If outside city or town limits, write RURAL and give nearest town)

Street No. ROUTE # 40

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME HAIG GALANJIKIAN Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 16, 1932

8. AGE:

Years	Months	Days	If less than one day
14	8		hrs. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER 12. Name Haig Galanjikian

13. Birthplace Constantinople

MOTHER 14. Maiden name Martha Jay

15. Birthplace Harford Co. Md.

16. Informant Henrietta D. Jay

Address Aberdeen, R.F.D.

17. Burial Date thereof May 17, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Presentia

Location Perryman, Md.

18. Funeral director Henry Tarring & Sons

Address Aberdeen Md.

19. May 17 1947 Nellie F. Riley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 15 1947, at 12:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Partial Carbonization	
Due to Conflagration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of 5/15/47

Where did injury occur? NEAR ABERDEEN HARFORD Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HOME

Means of injury Fire in Home Injured at work? —

23. SIGNATURE Jos Lamney M.D.

County Medical Examiner or other

Address Aberdeen, Md. Date signed 5/15/47

4511

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Diat. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Harford

City or town Institute Hall R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town White Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural - Blacks House Ind.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jennie M. Gemmill

3. (b) Social Security Number 214-12-2528

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 6 - 1886

8. AGE: Years 61 | Months 1 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Stewartstown Pa.

(Town, county, and state)

10. Usual occupation Dress maker

11. Industry or business

FATHER 12. Name William E Gemmill

13. Birthplace Pa.

MOTHER 14. Maiden name Elizabeth Ann Campbell

15. Birthplace Pa.

16. Informant Miss Jennie Gemmill

Address White Hall Ind

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15-1947 (month) (day) (year)

Cemetery or crematory Mountville

Location Mountville Ind.

18. Funeral director Howard D Mankin

Address White Hall Ind

19. May 15 1947 (Date rec'd by registrar) Thomas R Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1947, at 11 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1947, to May 12 1947

and that I last saw h e alive on May 10 1947

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE C. W. France M. D. or other

Address Darlington, Md. Date signed 5/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

516

04103

Reg. Dist. No. 186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Harford County
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital -
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Monkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Mr. James Carroll Hanna

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Wh.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 27, 1877

8. AGE: Years: 69 | Months: 10 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harford County, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: John C. Hanna
13. Birthplace: Md.

MOTHER
14. Maiden name: Priscilla Kean
15. Birthplace: Md.

16. Informant: Edgar Durham
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 29/47 (month) (day) (year)
Cemetery or crematory: St Ignatious
Location: Hickory, Md

18. Funeral director: Dean & Foster
Address: Relair Md

19. May 27 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May, 26th 1947 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..
and that I last saw him alive on May 26th 1947

Immediate cause of death	DURATION
Cachexia and heart failure	unknown
Due to: Carcinoma of Prostate	
Due to:	
Other conditions: Metastasis to 2nd lumbar Vertebra and pelvic carcinomatosis	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op. —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John F. Noguera M.D. M. D. or other
Address: Harford Mem. Hospital Date signed: 5/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a CB

CERTIFICATE OF DEATH

041014

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Harford
City or town Bel air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs
Hospital, Institution, or street address where death occurred:
Fountain Green Hospital
How long in hospital or institution? 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State N.C. County Alleghany
City or town Rural - Sparta
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Sherman Hudson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Wh	Widowed

8.(b) Name of ~~husband~~ or wife Alma Rost Hudson

7. Birth date of deceased (mo., day, yr.) April 26, 1866

6.(c) If alive, give age ..... years

8. AGE: Years 81 | Months — | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace Alleghany Co. N.C.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Joseph Hudson
13. Birthplace ~~England~~ Virginia

MOTHER
14. Maiden name Nancy Nash
15. Birthplace Ashe Co. N.C.

16. Informant Willard P. Hudson
Address Forest Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24-1947 (month) (day) (year)
Cemetery or crematory Mt. Zion
Location Fountain Green Md.

18. Funeral director Clarence E. Arthur
Address York Md.

19. 5/23/47 (Date rec'd by registrar) Priscilla Fonwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1947, at 8:45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1945, to May 22 1947
and that I last saw ~~him~~ alive on May 22 1947

Immediate cause of death Lobar Pneumonia — DURATION 6 da

Due to Fractured Rib — 10 wks.

Due to

Other conditions ~~Fractured~~ Chr. hypertension — 2 yrs.
Cardio Vascular disease.
Pernicious anemia (Include pregnancy within 3 months of death) — 2 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~ Fall Date of Mar 9, 1947
Where did injury occur? Bel Air (City or town) Harford (County) Md (State)
Injured at home, farm, industry, public place (where?) Fountain Green Hosp.
Means of injury Fall Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other
Address Forest Hill Md Date signed 5/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

04105

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred

St. Francis Villa

How long in hospital or institution? 6 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. Market & Commerce

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Sister Mary Catherine (Anna Kennealley)

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 24, 1899

8. AGE: Years	Months	Days	If less than one day
47	5	10	... hrs. ... min.

9. Birthplace Wilmington Del.

(Town, county, and state)

10. Usual occupation Retired Teacher

11. Industry or business —

FATHER

12. Name David Kennealley

13. Birthplace Wilmington Del.

MOTHER

14. Maiden name Rosanna Taggart

15. Birthplace Wilmington Del.

16. Informant Sister Rebecca

Address Market & Commerce Sts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/7/47 (month) (day) (year)

Cemetery or crematory Cathedral

Location Wilmington Del.

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. May 6 1947 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1947, at 10:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1947, to May 4 1947

and that I last saw h... alive on May 4 1947

Immediate cause of death	DURATION
Arteriosclerosis	
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Pneumonia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. (M. D. or other)

Address Havre de Grace Date signed 5/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46d

CERTIFICATE OF DEATH

04106

Reg. Dist. No. 782

1. PLACE OF DEATH:

County: Harford

City or town: Cardiff

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Cardiff

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Benjamin Lloyd

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Sarah E. Lloyd

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1882

8. AGE: Years	Months	Days	If less than one day
65	2	24	...hrs. ...min.

9. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Plasterer

11. Industry or business

FATHER
12. Name: Robert W. Lloyd
13. Birthplace: Wales

MOTHER
14. Maiden name: Mary Davis
15. Birthplace: Wales

16. Informant: Mrs. Sarah Lloyd

Address: Cardiff, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18, 1947 (month) (day) (year)

Cemetery or crematory: Slate Ridge cemetery

Location: Delta, Pa.

19. Funeral director: Hubert P. Harkins

Address: Delta, Pa.

19. May 17 19 47 M. M. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A

20. DATE OF DEATH: May 15 19 47, at 10.40

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 47, to May 15 19 47 and that I last saw h... im alive on May 15 19 47

Immediate cause of death	DURATION
intestinal obstruction	
Due to carcinoma of the large bowels	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Benjamin Lloyd M.D. or other

Address: CARDIFF Date signed 5-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

4512

46 ft

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Howard

City or town: Monrovia (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Howard

City or town: Monrovia Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna M. McElwain

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Walter McElwain

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): October 15 1884

8. AGE:

Years	Months	Days	If less than one day
60	7	2	hrs. min.

9. Birthplace: York Co Pa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeping

FATHER

12. Name: Stephen B. Hamilton

13. Birthplace: York Co Pa

MOTHER

14. Maiden name: Sarah Fitz

15. Birthplace: York Co Pa

16. Informant: Walter B. McElwain

Address: Monrovia Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19 1947 (month) (day) (year)

Cemetery or crematory: Lutheran

Location: New Oak Pa

18. Funeral director: H. Howard Hott

Address: Union Grove Pa

19. May 19 1947 (Date rec'd by registrar) Thomas P. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1947, at 2:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 13, 1947, to May 17, 1947 and that I last saw h.m alive on May 16, 1947.

Immediate cause of death	DURATION
Intestinal Hemorrhage	
Due to Carcinoma	
Due to Colon	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Norman H. Gramill M.D. M. D. or other

Address: Stewartstown, Pa. Date signed 5/19/47.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
JUL 22 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04107

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred: St. Francis Villa

How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. Market & Commerce

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sister M. Nunzio (Mary Anne Conway)

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 9/8/1872

8. AGE: Years	Months	Days	If less than one day
74	8	0	...hrs. ...min.

9. Birthplace Ireland (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business —

FATHER 12. Name John Conway

13. Birthplace Ireland

MOTHER 14. Maiden name Anne Ward

15. Birthplace Ireland

16. Informant Hospital Records

Address Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/10/47 (month) (day) (year)

Cemetery or crematory Glen Riddle

Location Near Wilmington Del.

18. Funeral director Cunningham & Son

Address Havre de Grace, Md.

19. May 9 1947 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1947, to May 7 1947, and that I last saw deceased alive on May 6 1947.

	DURATION
Immediate cause of death: Cerebral Thrombosis	
Due to: Hemiplegia	
Due to: Cerebral Hemorrhage	
Other conditions: Tuberculosis (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Charles J. Foley M.D. M. D. or other

Address Havre de Grace Date signed May 9 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

04108

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Rural — Fallston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural — Fallston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Blanche E Poulton

3. (b) Social Security Number

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: Mom

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 16 1872

8. AGE: Years 74 | Months 5 | Days 6 | If less than one day: hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business: Sewing Factory

FATHER
12. Name: John P Poulton
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Catherine Price
15. Birthplace: Baltimore Md

16. Informant: Miss Catherine W Mercer
Address: Fallston, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24/47 (month) (day) (year)
Cemetery or crematory: Friendship
Location: Fork, Md

18. Funeral director: H & Bailey
Address: Darlington Md

19. 5/24 1947 (Date rec'd by registrar) Priscilla Fawcett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1947, at 5:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1946, to May 22 1947
and that I last saw her alive on May 22 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	8 da.
Due to ESSENTIAL HYPERTENSION	?
Due to	
Other conditions GEN ARTERIOSCLEROSIS	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or Other
Address Forest Hill Md Date signed 5/22/47

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

POULTON
FRIEZER

Evidence for the change of age is shown on 93d

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04109

FILM No. G 11 C JUL 1 - 1947

Reg. Dist. No. 182

1. PLACE OF DEATH:

County Harford

City or town Rural - Bel Air
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Harford Convalescent Home

How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Harford

City or town Rural - Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No. Kalmia
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME CORA SCARBOROUGH

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6. Single, married, widowed, or divorced: Widow

6.(b) Name of husband: Howard Scarborough

6.(c) If alive, give age: Dec'd years

7. Birth date of deceased (mo., day, yr.): Jan. 30 1877

8. AGE: Years 70 Days 1st Months 3 Days 26 If less than one day: hrs. min.

9. Birthplace: Harford Co. Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER 12. Name: Solma Thomas

FATHER 13. Birthplace: Harford Co. Md.

MOTHER 14. Maiden name: Sarah England

MOTHER 15. Birthplace: Harford Co. Md.

16. Interment, Removal, Cremation: Burial

Address: Street, Md. R. F. D.

17. Burial, Cremation, Removal, Entombment: Burial Date thereof: May 28 1947 (month) (day) (year)

Cemetery or crematory: Ascension Cem.

Location: Harford Co. Md.

18. Funeral director: H. S. Bailey

Address: Darlington, Md.

19. May 27 1947 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1947 at 6:00 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1946 to May 26 1947

and that I last saw her alive on May 20 1947

Immediate cause of death: CEREBRAL HEMORRHAGE — DURATION: 20 days

Terminating

Due to: Chr Essential Hypertension — 3yrs?

Due to:

Other conditions: Chr Myocardial Disease?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill, Md. Date signed: 5/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

CERTIFICATE OF DEATH

04110

Reg. Diat. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? — 2 yrs.

Hospital, institution, or street address where death occurred:

—

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. Stokes + Friend

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Alice Etta Smith

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife Thomas F. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2/16/1894

8. AGE: Years	Months	Days	If less than one day
53	2	21	..... hrs. ..... min.

9. Birthplace Talbot Co.

(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business —

FATHER 12. Name George T. Henry

13. Birthplace Worcester Co.

MOTHER 14. Maiden name Alice Rideout

15. Birthplace Bozman, Talbot Co.

16. Informant Thomas F. Smith (Husband)

Address Stokes + Friend

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/10/47 (month) (day) (year)

Cemetery or crematory Arbutus

Location Baltimore

18. Funeral director Taylor Cooper

Address 510 Carlton Ave., Balto. Md.

19. May 7 1947 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1947, at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1947, to May 7 1947

and that I last saw h.. alive on May 7 1947

Immediate cause of death	DURATION
Acute Myocarditis	
Due to Pulmonary Oedema	
Due to	
Other conditions Cardiac Failure	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley Jr M. D. or other

Address Havre de Grace Date signed 5/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

838 04111

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 815 Otsego St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME William Stimax

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Marr.

6.(b) Name of husband or wife: Mrs Nora Stimax
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): 9-5-1884

8. AGE: Years: 62 Months: 8 Days: 4 If less than one day: ...hrs. ...min.

9. Birthplace: Caroline Co., Md (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: Md State Road

FATHER
12. Name: Isaac Stimax
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Nora Stimax
Address: 815 Otsego St, Havre de Grace Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 13, 1947 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Perryville, Md. Rural

16. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.

19. May 12 1947 (Date rec'd by registrar) C. L. Tewis Sr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9th 1947 at 11 46 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1947, to May 9th 1947 and that I last saw h... alive on May 9th 1947

Immediate cause of death	DURATION
Congestive heart failure	
Due to: Recurrent cerebral thrombosis	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Noguera MD (M. D. or other)
Address: Harford Mem Hosp Date signed: 5/10/47

M

(I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

04112

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hrs.

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 7 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 516 Freedom St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Baby Boy Sumpter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	B	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 16, 1947

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 55 min.

9. Birthplace: Havre de Grace Harford, Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Fortune Sumpter

13. Birthplace:

MOTHER — 14. Maiden name: Mary Snell

15. Birthplace: South Carolina

16. Informant: Harford Memorial Hospital

Address: Havre de Grace, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-19-47 (month) (day) (year)

Cemetery or crematory: St. James Cemetery

Location: Havre de Grace, Md.

18. Funeral director: Elmer E. Bullock

Address: 536 Lewis St. Havre de Grace, md

19. May 18 1947 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1947 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1947 to May 17 1947 and that I last saw h... alive on May 17 1947

	DURATION
Immediate cause of death: Patent foramen Ovale	
Due to: premeaturity	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Emery Wolbert M.D. M. D. or other

Address: Havre de Grace Date signed: May 18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 110 MAY 12 1947

CERTIFICATE OF DEATH

46f

04113

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 No. Union Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Marie Barry Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Clinton A. C. Wilson
6.(c) If alive, give age: 7. years

7. Birth date of deceased (mo., day, yr.): Sept. 5, 1878

8. AGE: Years	Months	Days	If less than one day
68	69- 7	26	hrs. min.

9. Birthplace: Phila. Penn.
(Town, county, and state)
10. Usual occupation: House Duties
11. Industry or business

FATHER
12. Name: Daniel Barry
13. Birthplace: Penn.

MOTHER
14. Maiden name: Louisa Scherr
15. Birthplace: Penn.

16. Informant: M. Clinton A. C. Wilson
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4 1947 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace, Md.

18. Funeral director: T. Madison Mitchell
Address: Havre de Grace, Md.

19. May 2 19 47 (Date rec'd by registrar) A. L. Lewis, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 19 47, at 7 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 19 47, to May 1 19 47 and that I last saw her alive on May 1 19 47

Immediate cause of death	DURATION
Coronary Embolism	
Due to Carcinoma of Liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: C. L. Lewis M.D. M. D. or other
Address: Havre de Grace Md. Date signed 5-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a CB

04114

CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred: Post Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County
City or town Philidelfelica
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1200 Loudon St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Boris Zeldin

3. (b) Social Security Number 091-05-1030

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Elizabeth Zeldin
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): 9-28-1879
8. AGE: Years 67 Months 3 Days 28 If less than one day ..... hrs. ..... min.
9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Machinist Engineer
11. Industry or business: Ladies Wear
FATHER 12. Name: Boris Zeldin
FATHER 13. Birthplace: Odessa Russia
MOTHER 14. Maiden name: Sarah Saranoff
MOTHER 15. Birthplace: Odessa-Russia
16. Informant: Jos. D. Nef
Address: Hotel Luther
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 18 1947 (month) (day) (year)
Cemetery or crematory: Philidelfelica
Location: Phila - Penna.
18. Funeral director: Henry Harring & Sons
Address: Aberdeen Md.
19. May 18 1947 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1947 at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from dead on arrival 19 to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Thos P. Thompson M. D. or other
Address Aberdeen Md Date signed May 18/47